POLICY: INDIVIDUAL SPECIFIC RISK MANAGEMENT

POLICY STATEMENT: It is the policy of the Bureau of Quality Improvement Services (BQIS) that individuals receiving services funded by the Developmental Disability, Support Services, or Autism waivers are protected from health and safety risks via identification and mitigation strategies that culminate in the implementation of risk plans.

DETAILED POLICY STATEMENT:

Identification of risk issues

1. The Individualized Support Team (IST) members shall be responsible for ensuring that risks to an individual's health and welfare are identified.
2. The Individual's Case Manager shall coordinate the IST's identification and mitigation of risks by:
    A. identifying individuals with needs resulting in an algorithm score of three (3) or greater as requiring risk plans addressing their needs;
    B. administering the Health and Safety Indicator (HSI) to each individual:
        i. on an annually basis, to coincide with the Individualized Support Plan;
        ii. on a quarterly basis; and
        iii. as needed, contingent upon a change in the individual's risk status;
    C. summarizing incident report data involving the individual for presentation to the IST when indicated;
    D. forwarding the "What is Risk? How to Plan for it?" booklet (Attachment "B") to the members of the individual's IST, when notifying members of pending IST meetings during which risk issues will be discussed; and
    E. chairing and documenting IST meetings during which an individual's risk issues are discussed and agreed upon:
        i. annually, to coincide with the Individualized Support Plan; and
        ii. as needed, contingent upon a change in the individual's risk status.

Development of a risk plan

1. The development of an individual's risk plan shall be the shared responsibility of the IST.
2. The Individual's Case Manager shall coordinate and document the IST's efforts towards developing a risk plan.
3. Dependent upon the identified risk, specific team members as agreed by the IST shall take the lead in preparation of a risk plan, such as but not limited to:
    A. the behavioral support provider for a behavior related risk issue;
    B. the entity responsible for health care coordination, for medically related issues.
4. Risk plans shall be developed and/or updated dependent one or more of the following:
    A. existing, known risks;
    B. a new risk for the individual;

C. ineffectiveness of an existing risk plan;
D. changes in circumstances with known risks.

5. A risk plan shall include the following components (see attachment "A"):
   A. Assessment/Outcome, which is:
      i. identification of risk issues; and
      ii. desired outcomes of the risk plan;
   B. Background Information, which is:
      i. history of identified risk; and
      ii. baseline information of risk;
   C. Planning & Implementation, which is:
      i. interventions to use with an identified risk;
      ii. method of monitoring risk;
      iii. directions for documentation of risk information;
      iv. notification instructions related to the risk;
      v. training required for the risk;
      vi. implementation of risk plan outside of the home;
   D. Evaluation, which is:
      i. record review of risk issues; and
      ii. analysis of findings.

Implementation of a risk plan

1. People providing direct services and supports to the individual shall receive training on implementing the individual's risk plans by the entity identified in the plan as responsible for training, including:
   A. provider employees; and
   B. family members.
2. Each member of the IST shall be responsible for ensuring equipment and supplies necessary for the implementation of an individual's risk plans are available in the location where the provider or family member provides services and/or supports to the individual.
3. Each member of the IST shall be responsible for ensuring provider employees and family members involved in the provision of services and/or supports to an Individual maintain documentation of implementation of risk plans developed for the Individual.

Monitoring a risk plan

1. Each individual' risk plan shall be monitored by the entities identified in the plan, who will take actions as indicated to ensure the effectiveness of the plan.
2. The Case Manager shall monitor risk plan implementation and data during routine case management services, bringing problems with management of risk to the attention of the IST when indicated.
3. The BDDS Service Coordinator (SC) shall monitor risk plan implementation for:
   A. individuals undergoing a transition from one service setting to another, or one service provider to another; and
   B. individuals identified as the subject of sentinel event incident reports.

and bring problems related to the management of an individual's risks to the attention of the Case Manager.

DEFINITIONS

"BDDS" means Bureau of Developmental Disabilities Services as created under IC 12-11-1.1-1.

"BQIS" means Bureau of Quality Improvement Services as created under IC 12-12.5.

"Individualized Support Team" means a team of persons, including:

1. an Individual;
2. the Individual's Legal representative, if applicable;
3. the Individual's Providers;
4. the Individual's Case Manager, if indicated;
5. a BDDS representative; and
6. other persons identified by the Individual or the Individual's Legal representative, if applicable,

who assist the Individual in the development and implementation of the Individual's ISP.

"risk" means the possibility or loss or injury, and/or something that creates or suggests a hazard.

REFERENCES

IC 12-12.5

Approved by: Julia Holloway, DDRS Director

Attachment "A"

ASSESSMENT/OUTCOME 1. Identified Risk Issue 2. Desired Outcome/Goal	BACKGROUND INFO 1. History of Risk 2. Baseline Information	PLANNING AND IMPLEMENTATION 1. Interventions 4. Notification 2. Monitoring 5. Training 3. Documentation 6. Out of home	EVALUATION 1. Record Review 2. Analysis
1. Identified Risk Issue • List risk issues as identified by the team. **2. Desired Outcome/Goal** • Desired Outcomes for the person; must be observable and measurable	**1. History of Risk** • Include when diagnosed, what was the cause of the problem, surgeries if applicable, etc. **2. Baseline Information** • What is the baseline &/or current status? • What is typical for the person? • Brief description of the risk issues/problems	**1. Interventions** a. What do you need to do? b. When do you need to do it? c. Who does it? d. When do you consider the next step? e. Are there things you need to do to prevent complications or further problems? **2. Monitoring** a. What do you need to watch /observe /monitor for? **3. Documentation** a. Who documents what? b. When and where do they document? **4. Notification** a. When and who do you call? **5. Training** a. Who will train when? b. What is the location of training documentation? **6. What do you do when out of home?** Address all of the above areas for when at work, day services, visits, trips, or any time outside of the home.	**1. Record Review and analysis** • Who reviews the data for problems and trends? • When do they review it? • Where is the review and summary of findings and actions documented?

If you do not know how to implement the plan or do not have the equipment or supplies to implement the plan, CALL _____!

IST Member Signature	Title	Date

IST Member Signature	Title	Date

What is Risk?
How to Plan for It?

A Guide for Consumers, Families & Others

1ST EDITION

INDIANA

BUREAU OF QUALITY IMPROVEMENT SERVICES

TABLE OF CONTENTS

Purpose of this guide

A. This guide was prepared primarily for people receiving services from the Indiana Bureau of Developmental Disabilities Services and their families and guardians. Additionally, case managers, Individualized Support team members and others who support people receiving services will find this booklet helpful.

B. This guide is intended to:

1. Make risks known to all team members;
2. Stress the importance of reducing risk through planning and team effort;
3. Explain what a risk plan is, how it is put together, and how it is monitored to see if it works or not;
4. Highlight the benefits of a risk plan to everyone involved in the life of a person receiving services;
5. Provide examples of risks that people receiving services often live with;
6. Clarify responsibilities for those involved with a person receiving services, as related to risk plans;
7. Describe what to do when a family member or guardian does not agree with the steps outlined in a risk plan, and the team is concerned about the dangers of not following the steps;
8. Discuss responsibilities of family members or guardians who decline to participate in risk plan development and implementation.

C. This guide includes the following documents:

1. An example of a written risk plan;
2. A copy of a “non-agreement” form;
3. A “Quick Reference Guide/Salient Summary” to risk planning
4. A feedback form to be used by any person wanting to help the Bureau of Quality Improvement Services make this guide better.

Introduction

***What is risk*? Merriam Webster defines it as:**

1. the possibility of loss or injury;

2. something that creates or suggests a hazard.

A little story about ***risk***:

Emily and Philip dated, fell in love, got married and had two children. The first, Anne, came into the world following an easy delivery and went through her early years without anything too unusual happening. She eventually left home for college, graduated, found a job, and moved into a new apartment. She's a nice young woman who is doing pretty well.

Kent, their second child, had problems shortly after his birth, and his life from day 1 has been anything but *"without anything too unusual happening"*. Early surgeries, lots of physical therapy, almost dying after eating Christmas decorations, and emergency room visits for seizures that won't stop are just a few of the *unusual happenings* to date. There have been lots of others. Shortly after his 21st birthday he developed diabetes which added to the list of worries he and his parents face every morning as they wake up and plan for the new day.

Talk about the **"the possibility for loss or injury"**... talk about **"something that creates or suggests a hazard"**... talk about ***risk***... Philip, Emily and Kent deal with risk almost every minute of every day (Kent has seizures frequently during the night). And it's not just the parents who have to be always alert to the dangers these everyday risks present to their loved one. Monday through Friday Kent leaves his parents' home for a day program which he really likes. He has made a lot of new friends there and his parents are pleased with the increase in independence they've noted as time passes. Emily and Philip don't go with him to the day program. They aren't there to watch over him and make sure he is not trying to ingest things that could make him sick - or worse. They are not there to catch the warning signs of an oncoming seizure, or to make sure that what he has for lunch won't make his blood sugar levels go haywire. Other people take over for them at the day program, as they also do on the occasional Saturday evening when Emily and Philip have the chance to leave their home together as a couple, rather than taking turns, one at a time.

Although the family depicted in the introduction to this manual is a fictional one, many people in our communities can relate to the fear and anxiety that goes along with the risks present in everyday lives of people with intellectual disabilities. It is hoped that this manual will assist not just moms and dads in dealing with these issues, but also Individualized Support Team members. Knowing that specific risks exist, knowing why those risks exist, planning for those risks, and watching to make sure plans are working as they should to prevent *"***loss, injury, or hazard***"* is what risk planning is all about. It is important. It is essential.

Why should we be concerned about risk and risk planning?

When a person with intellectual disabilities receives services approved through the Bureau of Developmental Disabilities, a lot of people become involved in those services. Family members, case managers, QMRPs, staff from Provider companies, and others make up a "team" that work together to get the person what they need. Very often the person receiving services has health or behavioral problems that can be harmful if not handled right. These conditions present "risks" for the person. Often it is the person themselves or their family members who know these risks best. The team has to know of these risks to make sure a plan is put in place to protect the person. Sometimes the team can develop the plan by themselves, and sometimes a specialist has to be called in to help. What results when the team does their job is that the risk is written down in a plan, the plan is shared with everyone who is involved with the person, everyone follows the plan, and the person avoids dangers that could happen if no plan was in place.

What is a risk plan?

A risk plan is a written set of guidelines and instructions for everyone who is involved with a person receiving services. It is developed through a team effort. The plan is often developed at the time of the Individualized Support Plan (ISP) and it is part of the ISP. When a risk issue develops or changes at any time of the year, the team should meet to change or add to the plan to keep it current and working.
The risk plan has a few key areas. They are:

Assessment: Information is collected and organized about actual or possible risk issues. It's important to know when, where, and how risk issues occur. It's important to know what has worked and what has not worked in the past. It's important to know how often a risk occurs, and how it affects the person's life. To complete a good assessment, the team will gather information from as many sources as possible, including the person receiving services, family members, health professionals, therapists, direct support staff, and case management staff. This information is written down using an assessment tool such as the Health and Safety Indicator (HSI) developed for case managers.

Desired Outcome/Goal: Outcomes and goals are written statements laying out positive results that the team wants to happen, focused on the specific risks to the person. These statements are written so that results can be watched and measured.

Prevention and Intervention Strategies: Strategies are actions that tell people what to look for, what to do, when to do it, who will do it, and who needs to be told about it. Strategies also include lists of things that should be watched for and written down. Often a risk plan may include strategies that are broken down into many steps. People who are going to be using these strategies need help in learning how to do them.

They need to be trained on all the different parts of each strategy so that they know how to do them correctly.

Evaluation: Looking at a risk plan from time to time to make sure it is working. Evaluation is looking at the information that has been written down or tracked for each risk issue. By reviewing the information the team can tell if goals have been met. If they have not been met, the team can look at what actions need to be taken to make sure the goals will be met in the future. The risk plan is changed as needed based on the results of the evaluation. A good evaluation of a risk plan is done by having everyone involved help with the evaluation.

What should we expect from a risk plan?

There are many things that the team should expect a risk plan to do when it is implemented by everyone involved with the person receiving services. One is to make sure that the signs and symptoms of a risk are recognized before they become so bad that the person's health gets worse, or they are have an injury. In addition to avoiding threats to the person's health or life, this will also prevent unwanted and costly doctor appointments and hospitalizations.

Medical issues are often discussed as risk issues, but risk plan development isn't always about health needs. Risk plans will also address a person's behavior and their environmental and safety needs. For example, if a risk can be managed with good behavioral interventions, or by creating a safer living environment, medication to treat nervousness or aggression may be used little or not at all. Risk planning provides a process for the person and their family to come together with other team members to make sure that all important information about the risks of the person receiving services, both past and present, is used to put together a plan. This will ensure the plan is a good one. A good risk plan is one that will work for any variety of services a person may be receiving, in many settings or places. A parent or guardian may find the risk plan helpful for other activities the person is involved with, such as church or other community based activities.

Who benefits from a risk plan?

When everyone helps to put together a risk plan, and everyone faithfully carries out the steps in a risk plan, everyone benefits. The team members benefit because they have a clear plan that tells them what to do, when to do it, who to report to, and what to watch for and write down. The guess work is taken out. The family benefits because they will not have to tell each member of the team who works with their loved one what they want and expect from them - they will already have this information. The risk plan assures them that good care will be provided when they are away from their relative. Most importantly, the person receiving services benefits because the interventions in the risk plan may help to prevent unnecessary illness, injury or other negative outcomes. Their quality of life will continue or be better as a result.

What are some commonly seen examples that would require a risk plan?

The following examples are areas that a person's Individualized Support Team would discuss, and some common risks for each area that would cause the team to develop a risk plan.

Area	Common Risks
Physical/nutritional management	Drinking, chewing, swallowing, and positioning issues – a person has a history of pneumonia and is prone to coughing and gagging at meal times unless food texture and liquid consistency is changed to prevent these problems. If food texture and drink consistency is not changed, the coughing and gagging can lead to further cases of pneumonia, or worse.
Health Maintenance	Example 1: A person with diabetes needs help in taking and writing down blood sugar readings at various times during a day, and knowing what to do when blood sugar levels are too high or too low. Example 2: A person with Constipation needs helps to keep track of bowel movements to prevent impaction.
Medication Administration supports	Example 1: A person does not always remember to take medication at the times she/he is supposed to, and needs reminders. Example 2: a person requires medication to be given immediately during uncontrolled seizures, or to prevent a severe reaction to a bee sting.
Use and care for adaptive and medical equipment	The person may require the use of special adaptive equipment for meals, assistance with changing position requiring special supports and lifts, or special medical equipment to help the person breathe better.
Chronic medical conditions	The person has Osteoporosis (brittle bones) and is unsteady on her feet. She falls easily. This person has had fractures and other injuries from falls.
Environmental safety concerns	Example 1: The person is home alone for some portion of the day, but does not know what to do if someone who should not be let in, comes to the door. Example 2: A person cannot set the water from the faucet at a safe temperature by themselves.
Community Safety	Example 1: A person does not follow safety rules while riding a bike in the neighborhood. Example 2: A person is unable to catch the right city bus and get off at the right

	stop without assistance.
Interpersonal Relationships Issues	A person has difficulty understanding what personal activity and information to keep private. Examples include the person sharing personal information about themselves and others with strangers; the person may change or remove clothes in public areas; the person does not close the bathroom door when using the bathroom or when bathing.
Behavioral Issues	A person engages in aggression toward others, property destruction, non-compliance, or behaviors that can lead to injury and/or legal problems.
Behavioral Health issues	A person has a psychiatric diagnosis such as depression, schizophrenia, phobia, post traumatic stress disorder, or autism. The person needs medication regularly without missed doses. Blood work is needed on a set schedule to make sure the medication is at the right level.
Protection and Advocacy	Example 1: A person is afraid of someone in their environment that they have to interact with every day. Example 2: A person will give money to others that they do not know, or purchase items that someone else needs, but that the person does not.

What is the Health and Safety Indicator (HSI)? How is it used to develop a risk plan?

The Health and Safety Indicator (HSI) is a tool used by an individual's case manager that checks for a person's risk in a variety of behavioral and health categories. Questions on the HSI focus on issues related to health, environment, behavioral needs and other factors important to the person's well-being. Results can help to point out why the person may be at risk. Teams use HSI results to help develop a person's ISP, and when necessary, a risk plan.

How are risk plans developed?

Risk plans are developed through an Individualized Support Team process. A parent, a family member, or a guardian is an important part of the team. Once a risk is identified any member of the person's team can call for a team meeting, using the case manager to get everyone together. The team will develop strategies that help to work toward removing risk, or at the very least lowering risk, to the person. These strategies will be the plan that everyone on the team agrees with and takes responsibility for. Risk plans are developed with most of the input coming from a clinician or medical person who is a professional in whatever area of risk is being discussed. For example if the person is at risk of harm due to behavioral episodes, a Behaviorist or similar position would develop the plan with input from the team. The case

manager/QMRP is responsible for ensuring the plan is committed to writing, and all team members sign the plan to confirm their agreement with it.

Are risk plans monitored? How do we know that they work?

Most risk plans include monitoring by watching and discussion with care takers. The plan may require that a checklist be completed to measure the type and seriousness of the episodes being monitored. Monitoring in some cases could also be daily or weekly handwritten notes recording observations. Staff members, case managers/QMRPs, family members or guardians may be called upon to record this information. These monitoring checklists or notes are then collected and used by the clinician and the team to check how the plan is working, and if it is necessary, to make changes. Any team member may ask for information about how any risk plan is working at any time by contacting the Case Manager/QMRP and requesting this information.

What are family members' responsibility when a risk plan is needed?

Working with the team to develop the plan is very important, as is agreeing to use the plan with the person receiving services. A family member or guardian could be called upon to complete a checklist on a regular basis, or to make notes of relevant episodes. This information is important to help determine if the risk plan is working and whether changes to the plan are needed.

What are some examples of information that might be collected from a risk plan?

The type of information collected depends on the plan and the risk issue being watched. In a case where a person may be drinking too much water, a risk plan would provide instructions that the person be watched closely for this behavior, and that the amount of water she drinks and the time she drinks the water be written down on a tracking sheet and reviewed on some schedule.

How do I know that the risk plan is working?

Using the information collected, regular reviews of that information, and in some cases additional assessment, team members identified as responsible for reviewing and reporting results would share the results with the team. If the information shows a positive outcome the team may decide to continue the plan as is. Additionally, a risk plan could be changed based on the information collected to better protect the person. Any team member may ask for information about how any risk plan is working at any time by contacting the Case Manager/QMRP and requesting this information.

What happens if the risk plan isn't working?

There may be times when the risk plan is not working as it was planned to. The numbers of episodes being monitored may have increased or not have changed at all. In this case the team will meet again to discuss why the risk plan may not be working. They need to discuss other strategies that could be developed, changes that might be helpful, or if a whole new plan should be developed that better addresses the risk issue. If the plan changes, team members are responsible for making sure that all staff and others

providing support to the person receiving services are notified of the change and know what the new plan calls for.

How does a family member get a risk plan started?

Any member of the team, including family members and guardians, may ask that the team discuss a risk plan anytime the person receiving services is felt to be at risk. This is done by contacting the person's case manager/QMRP and requesting a team meeting for this purpose.

What if a person wants to take some risks, and family members agree?

(dignity of risk)

We all have the right to place ourselves in a risk situation. However, none of us have the right to place others at risk. If the risk at question is a danger to the person receiving services or to others, the person receiving services should be provided the assistance they need to better understand the consequence of their actions. The team or a clinician as indicated by the person's circumstances can help with plans to do this. If a risk is identified and the person receiving services, or a family member, or a guardian refuses to participate in a risk plan, they will be asked to sign a statement indicating their refusal to participate. Refusal to participate should be done with as much information available as is possible. In some cases a family member, guardian or person receiving services may feel that they are not getting the information they need to make this decision. In these cases the case manager/QMRP should be requested to assist with getting the needed information. It should always be understood that the team's responsibility is to limit risks and that the team will act to limit risks as much as is possible as they assist the person receiving services with needed supports.

What if a person or family member doesn't agree with a risk plan?

If you are the person receiving services or any other member of the Individualized Support Team and you do not agree with the content of the risk plan, the team would continue to work towards an agreement. This process is referred to as **negotiating a risk plan.** Any team member may express disagreement with any plan, and continue to work with the team to negotiate a plan that will address concerns of the whole team.

What if I a family member does not want to participate in developing or implementing a risk plan?

If there is a need for a risk plan, input from family members is important. A family member or guardian may be the person who knows the individual best and can contribute the most. However, if the person receiving services, a family member, or a guardian refuses to participate in risk plan development, the team may complete the plan without input from the refusing person. After having had the opportunity to review the risk plan, a person receiving services, a family member, or a guardian may decide not to use it. If this happens, those involved may be required to sign a statement indicating their refusal to participate.

NON-AGREEMENT WITH RISK PLAN

Client Name: _____

Date: _____

(GUARDIAN)

I _____ (guardian/parent/caregiver) have been informed by the team that
(guardian name)

_____ may be at risk for _____ due to _____
(individual's name) (state probable negative outcome) (describe behavior/health issue)

On _____ members of the team met to formulate a risk plan on his/her behalf. I was invited to participate
(date of meeting)
in that meeting as a member of the team. At that time I disagreed with the terms of the plan and have been given the opportunity to meet with the team again to negotiate alternatives to the plan. I continue to disagree with the terms of the plan and refuse to follow the plan's instructions. The risks of this decision have been explained and I understand the possible negative outcomes of failing to participate. I understand that the case manager and the team will periodically meet to discuss this with me and revisit my concerns.

SIGNATURES

Guardian: _____ **Case Manager: _____**

Witness: _____ **Printed Witness Name:_____**

(EMANCIPATED ADULT)

I _____ have been informed by my case manager and my team that I may be at risk for
(individual's name)

_____ due to _____. On _____ I met with my team
(state probable negative outcome) (describe behavior/health issue) (date of meeting)
to formulate a risk plan to address this issue. At that time I disagreed with the terms of the plan. I have been given the opportunity to meet with my team again to negotiate alternatives to the plan. I continue to disagree with the terms of the plan and refuse to participate in the plan. The risks of this decision have been explained and I understand the possible negative outcomes of failing to follow the risk plan. I understand that the case manager and my team will periodically meet with me to discuss this and revisit my concerns.

SIGNATURES

Individual: _____ **Case Manager: _____**

Witness: _____ **Printed Witness Name:_____**

BDDS RISK PLAN (Sample)

Name _____ DOB_____ Date Developed_____

ASSESSMENT/OUTCOME	**BACKGROUND INFO**	**PLANNING AND IMPLEMENTATION**	**EVALUATION**
1. Identified Health Risk **Issue** **2. Desired Outcome/Goal**	**1. History of Health** **Risk** **2. Baseline Information**	**1. Interventions 4. Notification** **2. Monitoring 5. Training** **3. Documentation**	**1. Record** **Review** **2. Analysis**
1. Identified Health Risk **Issue** • Fall risk- especially 24 hours after seizure **2. Desired Outcome/Goal** • No injury for falls will occur within a 24 hour period after a seizure.	**1. History of Health** **Risk** • Diagnosed with (Tonic-Clonic) seizures since age of 10 yrs. Post seizure, unsteady on feet – especially in first few hours. Greatest number of fall activity is during this period. **2. Baseline Information** • Fell 12 times in past year, 10 of them during post seizure activity. • Unsteady on feet	**1. Interventions and Monitoring** • All staff will check the seizure log to see if (Person) had a seizure in last 24 hours at start of shift. • When seizure has occurred: Support by standing to side and slightly to (person's) back when helping her to transfer. Keep paths clear. Keep shoes or slippers on feet during transfer. Remind person to call for help before getting up. Anticipate need for moving by checking on (Person) every hour while awake for 24 hours after seizure. Check for injury if fall occurs. **3. Documentation** • Document falls and any injury on accident report by end of shift to program director. • All staff will be trained in ambulation assistance by nurse prior to working with (Person).	**1. Record Review and analysis** 10. All accidents will be reviewed by the team on a quarterly basis and the plan will be modified as needed to reduce falls. 11. The review will be summarized in the quarterly review and placed in the (Person's) personnel record.

	when moving from bed, chair or car. Falls back and can hit head. • Has had two head injuries treated in ER.	• Staff training records located in agency's office. **4. Notification** 7. Notify nurse immediately if injury suspected 8. Notify supervisor of any falls **9.** Notify program direct of any injury. **5. Training** • All staff will be trained to competence in ambulation assistance by nurse prior to working with (Person). • Nurse will evaluate continued competency on a yearly basis and document in training record.	
	.	6**. What do you do when out of home?** • Address all about interventions and monitoring areas when outside the home	

If you do not know how to implement the plan or do not have the equipment or supplies to implement the plan, CALL _____

IST Member Signature	Title	Date

IST Member Signature	Title	Date

Risk Plan Development
Quick Reference Guide/ Salient Summary
Bureau of Quality Improvement Services

A. <u>Why the concern about risks and risk planning?</u>

Individuals receiving services often have health or behavioral problems that if not supported properly and consistently by everyone who assists them day in and day out, will present dangers to their health and welfare.

B. <u>What is a risk plan?</u>

A risk plan is a written set of guidelines and instructions in a standardized format that addresses an identified risk issue. It is developed through the effort of the Individualized Support Team for use by everyone involved with the person receiving services. The plan may be developed at the time of the Individualized Support Plan. The plan can change to ensure progress, or a new plan can be developed for new issues, at anytime during the year with the team meeting to ensure agreement and distribution. Risk plans are developed with the following components:

1. Assessment/Outcome
2. Background Information
3. Planning and Implementation
4. Evaluation

C. **Who benefits from a risk plan?**

Everyone benefits. More specifically:

1. The Individual receiving services is protected from dangers to their health and welfare;
2. The family or guardian benefits due to everyone involved in providing services to the Individual being aware and trained on existing risks on an ongoing basis.
3. The Individualized Support Team benefits by avoiding expenditure of time and resources on negative, often life-threatening events that could have been avoided.
4. All provider staff involved in services to the Individual benefit by having factual information and direction on how to respond in the correct way to the special needs of the Individual.

D. Some examples of well known needs that would require a risk plan:

1. Dysphagia, or difficulty with swallowing (food or liquids);
2. Health maintenance focused on issues such as diabetes, constipation, osteoporosis;
3. Environmental safety associated with issues such as water temperatures during hygiene, appropriate floor coverings for adaptive equipment, supervision needed in community settings.

E. What role does the Health and Safety Indicator (HSI) play in a risk plan?

An HSI is a tool used in waiver settings to assess for risks associated with an individual's health and welfare. It is implemented on a regular basis, and on an as needed basis, anytime a change in status occurs or a new risk is identified or suspected. It serves to provide a means for follow-up by the case manager and Individualized Support Team for real or suspected risk issues.

F. How are risk plans developed?

1. The Individualized Support Team is responsible for ensuring risk plans are in place for the needs presented by the Individual receiving services.
2. Any person on the team may at any time request a team meeting to discuss the need for a risk plan, or a change in an existing risk plan.
3. The team decides how the plan will be developed, and if a specialist, medical or otherwise, is needed for either assessment or assistance with the plan components.
4. As with all Individualized Support Team meetings, the Case Manager (or QMRP in settings other than waiver) is responsible for coordinating the team meeting and for documenting the team meeting's outcome.

G. How are risk plans monitored and updated?

1. The risk plan includes a component that identifies what data collection, observation or other means of monitoring is needed for each specific risk identified for an Individual receiving services. This includes the party responsible for each specific data component.
2. The case manager will ensure the monitoring data is shared with all members of the team as indicated in the Individual's specific risk plan.
3. The case manager is responsible for ensuring the Individualized Support Team uses the data collected as described in the risk plan, to make changes as indicated.

H. Do family members and guardians participate in development and implementation of an Individual's risk plan?

Family members or guardians who are members of the Individualized team participate in the development and implementation of a risk plan. It is a primary responsibility of the Individualized Support Team to reduce risks to the Individual receiving services and to protect their health and welfare. The development and implementation of risk plans is a key activity to this end.

I. What happens if the Individual receiving services, a family member, or a guardian chooses to not participate in either the development or implementation of a risk plan?

As a member of the Individualized Support Team, the Individual, family member or guardian can raise their concerns with the team during a formal team meeting. At that time, the remaining members of the team are expected to take these concerns into consideration and to work together with the dissenting team member to provide additional information as may be needed and to negotiate a plan that the team as a whole can agree to. If this is not possible and the Individual, family member or guardian continues to not agree with the risk plan that the remaining team members feel is essential, the Individual, family member or guardian will be asked to sign a statement indicating their refusal to participate.

Feed Back and Evaluation Survey - Risk Plans

Please let us know whether this booklet is helpful, and if you have suggestions for improving it, by returning the completed survey via U.S. Postal service. Fold, tape, affix postage and drop in your nearest mailbox.

1. How helpful is the Consumer Guide to Risk Planning as a source for information?

_____ very helpful _____Helpful _____ Somewhat helpful _____ Not helpful

2. Overall, how satisfied are you with Consumer Guide to Risk Planning?

_____ very satisfied _____Satisfied _____Somewhat satisfied _____ Not satisfied

3. What do you think about the length of the booklet and how well risk planning is covered?

_____Too short/not enough information _____ Just right _____ Too long/too much information

4. Which describes your interest in Risk Planning and this booklet?

_____ I am currently receiving services under a waiver
_____I have recently been "targeted" for a waiver setting
_____I am on the waiting list for a waiver
_____ I plan to apply for a waover
_____I will use the book to educate others planning for risks

5. Which describes you? (please check all that apply)

_____ Person with a disability _____Parent of a person/child with a disability
_____ State agency personnel _____ Service provider
_____Advocacy organization _____Parent group
_____Educator _____ other (please identify_____)

6. Comments and suggestions:

7. If you like to sign up for email delivery of a variety of information generated and managed by the Division of Disabilities and Rehabilitative Services, please go to: **http://www.in.gov/fssa/ddrs/3894.htm** to view selections and to sign up.

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